GROUP COHESION WITH HARD-TO-TREAT YOUTH: ATTACHMENT INFORMED

DRAMA THERAPY AND THE THERAPLAY MODEL

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ABSTRACT

GROUP COHESION WITH HARD-TO-TREAT YOUTH: ATTACHMENT INFORMED
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DANIEL WILLIAM WOOD

The purpose of this paper is to propose an intervention design to facilitate group cohesion in therapy with hard-to-treat youths. This research paper is an abridged intervention research design comprised of a literature review and an intervention proposal but does not include an assessment of the intervention. The literature review covers current findings on trauma, neglect, attachment, group therapy, the Theraplay model of treatment, and drama therapy. Trauma, neglected and attachment disruption can lead to difficulties with self-regulation, self-belief, and trust in others which can impede an individual's ability to function in a group therapy setting. In this intervention, the first step to working with individuals affected by trauma, neglect and attachment disruptions is to focus on building skills around self-regulation using the body, through rhythmic and physical interventions. Secondly, a feeling of safety is facilitated through structured activities and playful social engagement. The proposed intervention outlines a three-phase model based on Theraplay and drama therapy which aims to enhance group cohesion, and improve an individual's self-regulation, self-confidence, and trust in others.

ACKNOWLEDGEMENTS

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Chapter 1. Introduction

There are many reasons that children are placed into groups. Science keeners might congregate at a museum's space camp. The love of outdoors may bring children together on nature excursions. From sports teams to daycare, children gather in and are assigned to groups. Often children in these settings are able to work collaboratively and enjoy the benefits of group interactions. To be a well-functioning member of a group an individual needs to be positively motivated by social interactions (Grunblatt, 2016). These individuals want to engage with others and have the requisite skills and experience to do so.

Social connection is a foundation of group therapy treatment; by working together and forming a cohesive group the developing brain can make positive changes (Cozolino & Santos, 2014). Group therapy aims to help a person on both an individual and social level (Badorff, 2016). Working in a group process allows children to learn, grow and change by interacting directly with others instead of through a didactic model (Shectman, 2016). By being in a social situation, individuals learn that they are worthy and appreciated by receiving positive feedback. This creates a corrective experience with peers and authority figures (Shectman, 2016).

Unfortunately, children in mental health treatment groups often have impaired social skills including an inability to connect with others, difficulty understanding feelings, and difficulty reading social cues (Haen, 2005). In addition to this impaired social processing, it is also common to find group members who have a negative view of their own self-worth and difficulty trusting other people (Haen & Aronson, 2016; Shactman, 2016).

The prevalence of child maltreatment among children with a mental health diagnosis is high. Perry and Gaskill (2014) point out that "The comorbidity of neuropsychiatric diagnoses associated with childhood maltreatment is so pervasive that it encompasses nearly all diagnoses in the new fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*" (p. 183).

Maltreatment and trauma lead to biological, cognitive and social difficulties which can isolate children and impede the healing offered by group therapy. They live tossed in an ocean of emotions and biological fear responses. Their developmental history has left them unable to 'steady their own internal ship' resulting in impulsive behaviour, labile emotions, and difficulty

focusing because their attention flits around the room looking for threats (Van Der Kolk, 2001). They have negative patterns around attachment and relationships, and experience difficulties communicating and connecting (Perry, Pollard, Blakley, Baker, & Vigilante, 1995). These children have a negative view of themselves and carry feelings of guilt and shame (Van Der Kolk, 2015). These children are often reacting to social situations based on past traumatic experiences and negative internal representations of self and other. This behaviour impacts their perception of, and participation in, group norms. Explained further by Malchiodi (2015) "Children who have experienced developmental trauma are often wary of relationships, even with a trusted therapist, because of early, repeated experiences of interpersonal violence and neglect" (p. 7).

In *The Boy Who was Raised as a Dog,* Bruce Perry (2006) writes that "children with aggressive or impulsive tendencies should not receive therapy in a group setting due to these children's tendency to increase rather than decrease negative patterns in each other" (p. 245). This lack of suitability for group treatment is an issue because, as Bruce Perry (2006) goes on to lament, more often than not, children who present negative behavioural patterns end up being lumped together, despite evidence that this is not the best practice.

The goal of this proposed intervention is to create a space that is safe, consistent and contained enough for these hard-to-treat clients to participate in a group therapy. By providing structured playful engagement, clear limits and achievable expectations the group will be able to have positive attachment experiences, moments of social success, feelings of relational competence, and the pleasure in being with others.

Chapter 2: METHODOLOGY

The methodology for this paper is an intervention research model, however due to ethical and time constraints, this paper will only use the first two of the five steps outlined by Fraser and Galinsky (2010).

Fraser and Galinsky's Method

Step 1: Problem and program theory. The first step in Fraser and Galinksy's (2010) intervention research methodology is to develop problem and program theory. Problem theory is "a portrayal of the individual and environmental factors" surrounding a problem (Fraser, Day, &

Galinsky, 2009, p. 49). Program theory "specifies the ways in which the intervention will change the mediating processes" (Fraser et al., 2009, p. 55). The development of this theory will be accomplished through a literature review focusing on the risk factors of trauma and neglect and their impact on self-regulation and social competence, the protective factors provided by secure attachment and the current theories on group therapy with children aged 7-12. Specific attention was paid to group theory arising out of the Theraplay model and drama therapy.

Step 2: Program structure. The second part of this paper will outline the program structure and process through the development of principals and a manual containing "an overview and session by session content that explains session goals, essential content and elective activities" (Fraser & Galinsky, 2010, p. 463). By correlating the current understanding of the effects of trauma and neglect and identifying attachment experiences that offer the potential to ameliorate some of these effects, a drama therapy group process will be created which draws from theories derived from Theraplay's attachment informed group therapy to create a manual for the intervention. A drama therapeutic approach to group work and attachment theory and attachment informed therapy will be applied as the key change strategy which will shape the creation of the intervention. This intervention has three main targets: increasing individuals' emotional regulation, self-esteem, and trust in others during a group therapy process.

Intervention Research

The question this intervention research aims to answer is "How can a group drama therapy process be informed by Theraplay to best support children aged 7 to 11 who present various emotional and behavioural difficulties which negatively impact their participation in a group therapy process?" As an abridged version of the classic Intervention Research Model the end-product will be a "detailed description of a new program or service" but not "an evaluation of the effectiveness of that program or service" (Fraser et al., 2009, p. 4).

There is currently no literature on the integration of the Theraplay Model with drama therapeutic process, however, play is considered a 'core process' in drama therapy (Jones, 2007) and there are a number of articles on attachment informed drama therapy. The choice of Theraplay as a main model came from the fact that it provides specific actionable theories which offer

a range of activities/interventions and the theoretical justification of how those interventions could affect an individual's attachment schema. It is my belief that the structure and containment offered by Theraplay can be blended with the social skills and self-esteem building potential offered by drama therapy to produce an intervention that will help clients who would often resist or sabotage a group process.

As stated by Fraser et al. (2009), "Designing an intervention requires making a strategic decision about where to start" (p. 49). The base assumptions being made in this paper are:

1. Developmental trauma and maltreatment can lead to difficulty navigating social situations (Booth & Jernberg, 2010; Levine, 2007; Malchiodi, 2015; Webber & Haen, 2016).

2. Difficulty navigating social situations can negatively impact one's ability to engage in a group therapy process (Haen, 2005; Ormont, 2004).

3. Positive attachment experiences increase an individual's ability to navigate social situations (Bate et al., 2017; Booth & Jernberg, 2010; Porges, 2015).

The above sequential argument leads to a reasonable starting point for this project. An informed assumption is made by the researcher that positive attachment experiences allow for participation in a group therapy process.

Data Collection and Analysis

The Data collection phase of this process started in the first month of my creative arts therapy training when I began working with hard-to-treat clients in a group setting. At that time, I was researching group process in both a classic psychotherapeutic model and in a drama-therapeutic model to inform my clinical work. My training—which involved readings in group therapy, drama therapy, play therapy, and trauma informed treatment models—led to a conceptualization of hard-to-treat clients which allowed me to structure an intervention approach based on Theraplay's attachment informed play therapy and drama therapeutic group process. Fraser et al. (2009) says "Indeed, intervention research may begin with a clinician who, with just one case, tries a new strategy and then writes down what she or he did" (p. 26). This research paper is simultaneously an examination of pertinent literature and an expression of clinical decisions made while working with various groups of children.

These practical foundations where built by reading articles suggested by my clinical supervisor and searching various databases such as Google Books, Google Scholar, ProQuest, PsycARTICLES, PsycInfo, and Taylor & Francis. Key search terms included, *complex trauma, attachment, creative arts therapy, group therapy, group play therapy, group drama therapy, Theraplay,* and *group cohesion.* There are three main themes that I was looking to understand when I read these texts: 1) impacts of trauma and neglect on behaviour and social ability; 2) group process with hard-to-treat children; and 3) secure attachment and its effects on self-regulation, self confidence, and social skills.

Validity and Reliability

This proposed intervention cannot be tested for its efficacy as it is only a pilot proposal, however, there are two facets which will help make this a credible research paper (Lincoln & Guba, 1985). Firstly, the literature review of this paper draws from a broad range of highly credible sources in the areas of trauma, attachment disruption, the Theraplay treatment model, and drama therapy. The second facet of credibility for this study is my own experience working with the population for whom I am designing this proposed intervention. This experience has helped me understand the data that I have collected and will inform the design of the proposed intervention.

Ethical Considerations

As a researcher I have committed to work in the realm of the theoretical and do not have ethics permission to perform research on the vulnerable population specified in the paper. However, as a clinician I work with this population and am ethically bound to provide my clients with the best possible care. Theoretical clinical improvements learned during this research process were implemented to aid my clients. Although my clinical work and research project are parallel, the two will only interact in so far as my clinical work builds a level of experience within myself. I believe that with appropriate supervision in both the clinical and research domain, and by keeping this concern present in my mind, I was able to maintain appropriate ethical boundaries during this project.

Further ethical considerations must be taken when choosing to apply this model to future groups. As these groups may be comprised of vulnerable populations, careful consideration will need to be used when evaluating the suitability of this model for those clients.

Assumptions and Biases

My own life experience has biased me towards believing in the benefit of group social interactions. I am the oldest of four siblings and the majority of my childhood experiences were in a group. As an actor, performer, and drama therapist I have a bias towards believing in the efficacy of the drama therapeutic approach. My aim for this proposed intervention is for the drama therapeutic approach to be safe and suitable for a broad range of clients. To that end, I will address adaptations of the structure which will allow future practitioners to meet the needs of individuals who are hesitant in both a play based and group setting.

Chapter 3. LITERATURE REVIEW

Trauma and Neglect

There are two distinct ways the brain can miss out on appropriate development: neglect and trauma. Neglect is a lack of necessary environmental or relational stimulus needed to create the neural activation in the brain for it to be able to "express the genetic potential of a core capability [like] self-regulation, speech and language, (and capacity for healthy relational interactions)" (Perry, 2009, p. 244). Trauma, on the other hand, creates an 'over-activation' of the stress response system. "Rather than a deprivation of sensory stimuli, the traumatized child experiences over-activation of important neural systems during sensitive periods of development" (Perry et al., 1995, p. 277). This over-activation becomes embedded as the 'normal' state for the developing brain and leaves a child with a sensitized, easily triggered, stress response system (Perry et al., 1995).

Impacts on self-regulation and sense of safety. Maltreatment and trauma change the shape of children's brains which directly impacts their ability to function socially (Gaskill & Perry, 2014). Even low-level attachment trauma, where a parent ignores or is angered by a child, can leave the child feeling unsafe and, over time, lead to deeply engrained negative models of self and other (Cozolino & Santos, 2014).

In an optimal environment, individuals learn the foundation of good social skills through an attachment relationship. Positive attachment leads to competent social skills and, inversely, negative attachment experiences, maltreatment, and trauma can lead to difficulty forming social bonds (Cozolino & Santos, 2014).

Collaboration and human connection are prerequisites for survival (Perry, 2009). A child sensing stress reaches out to the primary caregiver. As a young child's stress response system is activated, an arousal response, namely crying, signals distress with the hope of bringing a care giver to the child's aide (Perry et al., 1995). According to Perry (2009), the caregiver offers the distressed child calming "patterned, repetitive neural simulation" (p. 247) which regulates the child and helps the infant develop their own ability to self-regulate.

In cases of children who have suffered trauma or maltreatment, crying doesn't necessarily lead to a soothing response from a care giver. When a child experiences persistent activation of their stress response system, this system adapts and the child subsequently develops a sensitized stress response system (Perry et al., 1995). A sensitized stress response system primes a child to be generally anxious and to react quickly to any perceive threat, easily escalating emotionally from anxious to terrified (Perry et al., 1995). Traumatized children's brains 'learn' from their trauma; this learning or 'sensitization' primes the brain to respond more readily to stress with a fight, flight, or freeze response (Perry et al., 1995). This leaves a child with a persistent feeling of danger and can lead a child to be aggressive, impulsive, emotionally reactive and hard to calm (Perry & Szalavitz, 2006). Children in this mode of thinking can also have difficulty directing attention and react quickly with heightened emotionality (Fonagy & Bateman, 2012; Van Der Kolk, 2015).

Attentional problems and heightened emotionality work together to negatively impact a child's social skills, resulting in impulsive and inconsiderate behaviour. Reactivity and difficulty focusing can increase an individuals likely hood of reacting to a situation motivated by previous models of social interaction and not based in the present situation (Fonagy & Batemen, 2012). What might seem like a minor difficulty or disagreement to an individual with a relatively 'normal' ability to self-regulate, can trigger a traumatized individual to react as if they are in extreme danger (Van Der Kolk, 2001). A child griped by the fight or flight response is living in a body

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flooded with hormones and instincts designed to help them survive in a life or death situation (Perry et al.,1995) Their eyes dart around the room, scanning for threats, they can't sit still, focus on a given task or take direction. They are jumpy and overreact to small problems. To an adult this lack of focus, emotionality, aggression, and oppositional behaviour can look like classic 'bad behaviour'.

In the face of persisting threat and, depending upon the age of the child and the nature of the threat, the child can respond with a "fight or flight" or a 'freeze' response (Perry et al.,1995). Freeze is an adaptive response that allows an individual to both increase their ability to sense danger, and to hide from danger with lack of motion (Perry et al.,1995). In some situations, the freeze response can be perceived by adults as oppositional defiant behaviour (Perry, et al., 1995). In a new situation, an anxious child will naturally feel an increase in anxiety. If an authority figure gives a child who is 'frozen with fear' a directive, this child will have a hard time complying with the request due to being frozen (Perry, et al., 1995). The child's refusal to participate leads to the adult listing consequences or punishments, which further increases the child's anxiety, deepening their defensive stance of freeze (Perry, et al., 1995).

Whether it is the coiled spring of fight or flight or the outwardly disaffected distance of freeze, traumatized children have difficulty allowing themselves "to flow, to play, to dance" (Harnden, 2014, p. 129). Because they have not experienced the necessary comforting connection, their ability to be with others is impaired:"..children who are anxious and insecure do not readily enter into rhythm, resonance and synchrony, and therefore find it difficult to understand the intentions of others and join in the interactive dance" (Hart, 2008, p. 92).

Impacts on Internal Working Models of self and other. Early experiences with care-givers shape a child's expectations of the way other people will act towards them, creating "implicit expectations that impact future social relationships" (Perry, 2009, p. 247). Without positive attachment experiences children create an inner working model of themselves as powerless and unworthy of love (Booth & Jernberg, 2010). They also carry an inner working model of others as being untrustworthy and unsafe (Booth & Jernberg 2010; Cozolino & Santos, 2014; Malchiodi, 2015).

Developmental trauma, often the result of repeated acts of relational violence and neglect, sets a pattern of mistrust in relationships (Booth & Jernberg, 2010; Malchiodi). Trauma and mal-treatment lead to relational adaptations. Negative attachment experiences can lead a child to be overly controlling and manipulative (Fonagy & Bateman, 2012). On a relational level, their body's natural response to trauma leads them to act against authority figures (Levine, 2007,).

On a personal level, trauma leads children to feel "helpless, confused, and ashamed" (Malchiodi, 2008, p. 3). If a child doubts their own value they can develop what Co-zolino and Santos (2014) call "core shame" (p. 161). Children in this situation lack a belief in their own innate value and live with a feeling of "worthlessness" which creates a need to hide who you are; a need to be perfect, so as to earn a place at the proverbial table (Cozolino & San-tos, 2014). These pervasive patterns of externally and internally directed doubt, and mistrust, greatly impede these clients' ability to work in groups. If a child's brain has been shaped by neg-ative attachment experiences, trusting a group of therapy participants and a therapist does not make sense. Some individuals are what Ormont (2004) would call an *isolate:* "They would rather be lonely than risk the unforeseeable dangers of joining the pack" (p. 66).

Social connection: Co-regulation and safety. Porges (2015) explains why children, whose brains are reactively wired by trauma, have difficulty connecting socially by proposing a hierarchal structure of safety-establishing brain systems. The earlier evolved systems, "i.e., fight–flight and death-feigning behaviours (freeze)" are utilized when the later developed system of "social communication and visceral homeostasis" fails to provide a sense of safety (Porges, 2015, p. 118). Humans seek safety. If we can achieve a feeling of safety through positive social experiences and social co-regulation the fight-flight-freeze systems do not need to come on-line, but if the social queues of safety are not present or perceivable, fight, flight, and freeze step in to ensure survival (Porges, 2015).

Porges' (2015) Polyvagal theory links feelings of safety and social co-regulation; "Func-tionally, the experiences of the infant in the mother–infant relationship provide opportunities for neural exercises to strengthen pathways that will enable social behaviour to regulate physiologi-cal state" (pp. 115-116). If a child experiences these key relational regulatory experiences when

young, their brain will develop in such a way as to allow for relational regulation later in life; if they are unable to have this experience, their ability to socially coregulate is negatively impacted (Porges, 2015).

Porges (2004) also proposes the term "neuroception" to codify the neurological, unconscious process that assesses safety and activates or inhibits the structures of the brain used in defence. When an individual 'neurocepts' a safe environment they shift from a defensive mode into a calm and socially engaged state (Porges, 2015). As this communication of safety is 'bi-directional,' safety can cue social engagement, and social engagement can cue safety (Porges, 2015). The social engagement systems allow for co-regulation; in early life a mother's soothing tones and smiling eyes are perceived by a crying infant's 'social engagement systems,' thus regulating infants in the moment and strengthening the neural pathways within the child, which will be used in the future to connect socially and establish a feeling of safety through social connection and co-regulation (Porges, 2015).

The Gift of Attachment

Booth and Jernberg (2010) explain the optimal attachment dynamic and its positive foundations:

> When things go well in the parent-infant relationship, the child develops an inner representation of himself as loveable, special, competent, and able to make an impact on the world; of others as loving, caring, responsive, trustworthy, and reliably available; and of the world as safe, exciting place to explore. (p. 57)

Bowlby (1990) defined attachment behaviour as "any form of behaviour that results in a person attaining or maintaining proximity to some other dearly identified individual who is conceived as better able to cope with the world" (p 26). This proximity-seeking behaviour increases in times of stress and, in general, creates a feeling of security in the vulnerable individual (Bowlby, 1990). In early life, a normally developed attachment system responds to stress cues by triggering a child to move closer to and receive soothing from a caregiver (Bate et al., 2017). In time, these repeated experiences of stress and comfort lead to the creation of positive "internal working models or mental representations of self, other, and relationships" (Bate et al., 2017, p.

99). These models shape expectations of where comfort can be found and how others are likely to respond to requests for care, and they also shape an individual's sense of their own worthiness to receive love from a care giver (Bowlby, 1973).

Bowlby conceives of caregivers as a secure base which offers support for the individual as they face the uncertainty of exploring the world around them. As they head out on their own; be it across the floor towards a pile of toys, across the park to new group of playmates, or across the continent to a new school, the internalized belief that one will be supported physically and emotionally allows for these risks to be taken (Bowlby, 1990).

The attachment system works in concert with the human drive to explore and discover; these two dynamics—one of safety and one of novelty— work hand in hand (Bate et al., 2017). When a child feels safe and supported by the closeness of a caregiver, through physical or psychological proximity, the child is able to interact with the strangeness of new things without that novelty leading to overwhelming fright (Ainsworth, 1979). One of the benefits of a secure attachment system is the ability to withstand the discomfort of novelty; secure attachment allows an individual to access "flexible, adaptive learning" whereas "insecure attachment supports rigid, trauma-based learning" (Cozolino & Santos, 2014, p. 169).

Secure vs Insecure. Ainsworth, through direct observation and clinical studies, identified three styles of attachment; 1) secure, where a child is concerned at his care givers absence, but readily accepts soothing when they reunite; 2) insecure anxious, where a child is distressed when the caregiver departs, continues to protest throughout the absence, and are unwilling to be soothed upon the caregivers return; and, 3) insecure avoidant, where the child appeared undisturbed by the departure of the caregiver and disinterested when they returned (Ainsworth, 1973; Ainsworth et al., 1978) A fourth style of attachment, disorganized attachment, was identified by Main and Solomen (1990), who observed that some children did not have a consistent style of attachment and did not have an organized system of responding to stress through attachment (Main & Solomon, 1990, in Bate et al., 2017).

Bate et al. (2017) characterize attachment styles as stress response strategies; learned styles of relating, which have grown out of consistent behaviour from the primary caregiver. A

child who is securely attached has an implicit sense of the consistency of the caregiver and, sub-sequently, can trust the caregiver to help them feel safe. Secure attachment helps a child develop the ability to understand feelings and mental states in themselves and in others. It also supports affect regulation and facilitates an inner sense of self-worth and the ability to trust others (Bate, et al., 2017).

The insecure attachment styles are negative, internalized belief systems shaped by styles of parenting that have left these children in doubt of their caregivers' responsiveness (Bate et al., 2017). Insecure attachment impedes a child's ability to build "sustaining relationships and to regulate stress" (Webber & Haen, 2016, p. 220). Insecure attachment can also impede an indi-vidual's ability to understand the mental states of others and themselves and can lead to a lack a coherent sense of self (Fonagy & Bateman, 2012).

Without the ability to relate to an adult as a 'secure base', a child is unable to fully devel-op a deep implicit belief in their own worthiness, strength and trust in others (Booth & Jernberg, 2010). A caring and predictable caregiver offers a developing brain the "repetitive neural stimu-lation" (Perry, 2009, p. 247) which helps build a robust stress response system and the ability to have positive relationships with others. In a therapeutic relationship the therapist can provide this secure base in order to support a client through the discomfort of growth (Bowlby, 1990).

In a way, the therapy process is an exploration of the world and the self. "We [Therapists] use the leverage of evolution via secure attachment, attunement, and empathy to stimulate plas-ticity in neural circuits of social and emotional processing" (Cozolino & Santos, 2014, p. 169). By using relational approaches that are similar to those of a parent the therapist helps the client build their own mentalizing capacity and the ability to self-regulate (Cozolino & Santos, 2014; Harnden, 2014). Malchiodi (2015) likens the approach of a creative arts therapist to that of a par-ent where being with a child and reflecting their experiences while the child works on an art project "mimics the neurological relationships between a caring adult and child" (p. 19).

Group Therapy with Children

Much research has been done on the therapeutic factors of group therapy and their links to effectiveness in therapy (Shechtman & Gluck 2005; Yalom 1995). Various studies have found

that different populations identify different factors as the most important (Shechtman & Gluck, 2005). Shechtman and Gluck (2005) state that for children's groups, the relationship-climate which "involves items related to the formation and maintenance of relationships in the group" (p. 128) has been identified as the most important therapeutic factor. Yalom (1995) defines cohesiveness as "the attractiveness of a group for its members" (p. 48) and encompasses feelings of "warmth and comfort in the group, feeling they belong, valuing the group and feeling, in turn, that they are valued and unconditionally supported by other members" (Yalom, 1995, p 48).

Yalom (1995) outlines the stages of group development as orientation, conflict, and finally, the development of cohesiveness. Orientation is characterized by a search for structures and goals, and learning the group's boundaries. The conflict stage deals with power dynamics and pecking order within the group. After working through the conflict stage a "mature work group emerges" (Yalom, 1995, p. 294). But what happens if a group cannot come together into a cohered unit? "To some participants, acceptance and approval appear so unlikely that they defensively reject or deprecate the group…" (Yalom, 1995, p. 295). This rejection of the group often happens with traumatized and neglected children who can easily mistrust relationships due to previous negative relational patterns (Malchiodi, 2015).

Shechtman (2016) points out a major difficulty facing therapists facilitating groups with children: they often lack the skills to be an effective member of a therapy group. Children need a therapist to model skills and show how to share feelings and how to support others while they share their feelings (Shechtman, 2016). Structure is key to creating a contained sense of safety and it has also has been shown to facilitate sharing by children in therapy (Leichtentritt & Shechtman, 1998). Citing research, Aronson (2012) explains that hard to treat clients tend to need a structured and experiential approach to group therapy (Frank, 1976; Schamess, 1986; Scheidlinger, 1960). These children work best when "limits are very clear, goals are manageable, and the children themselves feel contained and nurtured" (Aronson, 2012, p. 597). Rubin (2010) recommends that "agitated, and emotionally needy children" (p. 503) should be in smaller groups as traumatized children need to have very structured activities for them to have a feeling of safety while in a group.

Fritz Redl, an early pioneer of group therapy, prescribed a strength based and developmentally informed approach to working with troubled youth (in Becker, 2001). Redl and Wineman (1965), in *Children Who Hate*, explain a treatment system for children who lack the normal ego development to allow for appropriate impulse controls. In these children, feelings of fear, anxiety, and guilt lead to disorganization and aggression (Redl & Wineman, 1965). Basic educational interventions fail with this type of population because often learning requires a "high level of frustration tolerance" which this population lacks (Redl & Wineman, 1965, p. 24). Redl and Wineman (1965) articulate two equally important needs for a clinician to consider regarding activity choice. Firstly, activities need to be enjoyable and appropriate to the clients' current abilities and, secondly, they need to be challenging enough to be interesting and lead to growth (Redl & Wineman, 1965).

Activity choice. Gaskill and Perry (2014) say that the 'key to treatment' is twofold: firstly the client must be regulated, they must feel safe, and secondly "relational and cognitive expectations" (p. 186) must fit that child's abilities. If a child is asked to participate in an activity that is too advanced for their developmental ability they will not be able to succeed, creating a feeling of failure which will trigger a feeling of danger. "The most effective intervention process would be to first address and improve self-regulation, anxiety, and impulsivity before these cognitive problems become the focus of therapy" (Perry, 2009, p. 252). To help these children, we need to first engage the body through movement, rhythm, and somatosensory interventions. This "patterned, repetitive neural input" (Perry, 2009, p. 243) helps shape the brainstem and monamine neural network (the stress response system), and helps children learn to regulate themselves. Once safety is established then clinical interventions, which build on the social stage of development, can begin (Perry, 2009).

Shechtman (2016) suggests an indirect approach to achieve these ends. Children often are unable to easily talk about their problems directly, often a more indirect play approach is recommended (Shechtman, 2016). This indirect approach can start with games and stories to help youth create distance between themselves and their problems and reduce anxiety around discussion of said problems (Shechtman, 2016). "Games, sports, crafts, and writing become the building blocks for a sense of self-confidence and can be implemented in the group therapy process,

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along with other techniques [like] creative drama [and] storytelling" (Lomonaco, Sceidlinger &Aronson, 2000, p. 430).

Using group activities to produce a sense of togetherness can both help children act in a way that is more 'advanced' than their normal behaviour and at the same time create a feeling of safety (Redl & Wineman, 1965). Giving children these experiences of social success creates a positive pattern, which can provide "a feeling of mastery which in itself may have a strengthening effect on its future possibilities" (Redl and Wineman, 1965, p. 141). By being able to succeed in a social situation, individuals learn that they are worthy and appreciated by receiving positive feedback; this creates a corrective experience with peers and authority figures (Shechtman, 2016).

The Black Jack model. Leben (2014) proposes a model of group play therapy based on what she calls "The Black Jack model" (p. 4). Her approach was developed to treat learning and social skills deficits in children diagnosed with ADHD. In the Black Jack model of group therapy, the therapist works with one child for a brief moment, while other children are watching and learning from this interaction. Leben links this format to the parallel play stage in child development that was articulated by Piaget (Leben, 2014). This concept of working with a group while using a one-on-one treatment approach also appears in Onoe's (2014) Improvisational Drama of Acceptance and Mirroring (IDAM). Onoe (2014) developed this approach while working with groups of hard-to-treat youth and is an adaptation of D.R. Johnson's DVT therapy. IDAM differs from traditional DVT group practice in that it uses the majority of the group as an audience and that only one client is working with the therapist at any one time (Onoe, 2014).

Therapists traits. Drama therapist Craig Haen (2008) writes about the difficulties of working with groups who have suffered from trauma saying that "Therapists who work with this population are continuously charged with the difficult tasks of engaging and building trust with clients whose ability to connect with an adult, and to process what has happened to them, is often compromised" (p. 226). Shechtman (2016) recommends that a group therapist blend both "a caring and enthusiastic" approach with and a "strong and assertive" approach so that they can set limits and establish norms that will enable the group to function (p. 56).

As children in group therapy often have a negative view of others and themselves, the therapist must express positive regard and excitement about the children and their positive behaviours in order to offer a corrective group experience (Shechtman, 2016). Shechtman (2016) says that key skills for working with groups of children are encouragement, interpretation, and therapists' self-disclosure. Interventions that fall in these domains aid group cohesion and outcomes (Shechtman, 2016). Inversely, and unlike adult group therapy, interventions that act as a challenge to the client negatively affect group process (Shechtman, 2016).

Structure and Containment

Resistance. Resistance in children is often seen in regressive and aggressive behaviours (Gerrity, 2004). Resistance can function as a test of the therapist to see if they will accept a child even if they are showing a less than acceptable side of themselves (Munns, 2009).

Resistance to therapy can appear as a challenge to the therapist; managing that challenge in a positive and containing way helps members feel safe with the therapist and the group (Fonagy & Bateman, 2012; Shechtman, 2016). The containment offered by a strong therapist who can confidently "set limits and establish norms" builds the foundation for a functioning group (Shechtman, 2016, p. 56). One way to show confidence is to avoid asking permission when starting an activity. Although it is normal to say "shall we move on?" when working with hard-to-treat children, asking the question offers space for the children to say "no" which can easily lead to a power struggle or argument. Better to confidently state the expectations of each activity and assume the group will follow (Booth & Jernberg, 2010). Theraplay therapist Munns (2009) suggests meeting resistance in an "upbeat, but firm manner" (p. 9) and to reflect feelings while at the same time moving forward with the activities in a positive way. Munns (2009) suggests joining the resistance and turning it into a new game, which is similar to drama therapist Rene Emunah's (1994) 'paradoxical approach' to dealing with resistance. Inversely Booth and Jernberg (2010) recommend dealing with resistance by anticipation and pre-emptive activities so that the resistance never begins in the first place.

Disturbing Emotions. Another aspect of group that requires containment is the holding of 'disturbing emotions'. By helping the group navigate through a trying emotional situation the

therapist shows their ability to contain and help the group gain understanding of these emotions (Aronson, 2012).

A key rule to enforce while working in a group therapy process is that of respect for self and others, "…forestalling destructive criticism and attacking behaviour must be a primary concern" (Dumais, 2016, p. 34). Later in a groups trajectory there is value in being able to facilitate constructive criticism and allowing for negative expressions amongst group members (Dumais, 2016). However, traumatized or neglected children often are unequipped to use negative feedback in a positive way (Shechtman, 2016). Aronson (2012) quotes Scheidlinger (1982) who explains that the group therapist must support and protect victims of group scapegoating and also help the group understand the motivations for this type of behaviour. Munns (2009) also recommends facilitating a hurt child setting a clear boundary by saying 'don't hurt me' to an aggressor and having the aggressor participate in some form of restitution, but to avoid shaming the aggressor.

Contracting. On overt expression of structure and containment can come from the group contract. A contract is a codification of collaboratively chosen "preferred behaviours that will inform and direct group participation" (Dumais, 2016, p. 30). Contracting with a group spells out safety concerns, sets norms of behaviour, and defines goals for the group (Dumais, 2016). Contracts usually contain rules that cover confidentiality, safety of bodies, emotions, and the space. (Aronson 2012).

In children's groups the therapist sets the social norms (Shechtman, 2016). Two key norms necessary to the group process are, expressions of one's feelings and support for other members of the group (Shechtman, 2016). These traits are both modelled by the therapist and enforced through activities and clear expectations, "With children, leaders are both authority figure and role model" (Shechtman, 2016, p. 55).

Group Theraplay uses four rules to help structure the activities; no hurts, stick together, have fun, the leader is in charge. These rules are both stated openly and modelled by the leader's behaviours (Rubin, 2010).

Drama Therapy

Drama therapy is the use of theatre process for therapeutic benefit (Emunah, 1994). Phil Jones (2007) separates three avenues of exploration that drama therapy offers: content, process, and relationships. Working with content allows for a client to project themselves into the dramatic material, and in so doing, gain insight on their inner world (Jones, 2007). The process of drama and creation help a client 'express and explore' their inner world in a safe space (Jones, 2007, p 10). Lastly drama therapy allows for relationships to be built while working together on the project of creation. This process of building relationships can help individuals practice "social interactions and the development of interpersonal skills" (Emunah, 1994, p. 33).

Core Processes. Core processes are "fundamental process within all dramatherapy" (Jones, 2007, p. 81). They are overarching concepts which "describe the ways in which drama and their forms and process can be therapeutic" (Jones, 2007, p. 81).

Play. Play is a core process in drama therapy, which facilitates change by creating a space for clients to loosen their preconceptions about themselves, their life experiences, relationships, and environment (Jones, 2007). Play can take the form of games, role play, rough-and-tumble play, and play with objects and toys (Jones, 2007).

The use of games, a highly structured form of play, figures heavily in the proceeding intervention. Viola Spolin (2011) points out the psychological benefits of game play; "While the game is an imaginatively set up structure into which the players project themselves psychologically, they act consistently with the demands of the situation, and thereby subject themselves to self-imposed discipline, which involves many aspects of social behaviour" (p. 401).

There are some games that children seem to know innately. The rules of such games are what Redl and Wineman (1965) describe as "neighbourhood codes" (p. 112). Games like hide-and-seek and tag are readily accepted by a group even if that group is often resistant to adult direction (Redl & Wineman).

Dramatic Projection. Dramatic Projection is the process by which clients see parts of their inner world reflected back to them from dramatic material, which allows them to "external-ize inner conflicts" (Jones, 2007, p 84).

Witnessing. In drama therapy witnessing occurs when a group or individual acts as an "audience" in a drama therapeutic setting (Jones, 2007). It is possible to act as a witness for oth-ers and for oneself (Jones, 2007). Jones (2007) states that being witnessed can facilitate the feel-ings of "acknowledgement or support" (p. 102).

Embodiment. Embodiment in drama therapy involves the way the self is explored and expressed by the body (Jones, 2007). In a drama therapeutic experience, the client can learn to "inhabit or use their body more effectively," transform their body and its habitual uses, and ex-plore how their body has been shaped by "personal, social and political forces" (Jones, 2007, p. 113).

Working in a drama therapeutic body can help integrate mind and body in a process of self-exploration (Jones, 2007). The use of the body also allows for the physical, as opposed to cognitive, processing of events and feelings (Jones, 2007).

Transformation. Transformation in drama therapy helps a client see the potential to change in themselves by highlighting transformations in the drama therapy space (Jones, 2007). Jones quotes Johnson's structure of transformation, saying that a client starts by "owning the ex-perience" then by "actively engaging with them in dramatic form" and finally by "resolving and integrating the material" (Jones, 2007, p. 121).

Throughout a drama therapeutic process, clients experience many transformations as they go from player to audience member, from hero to villain; objects transform as props are instilled with other uses or meanings, even the relationship between therapist and group transforms (Jones, 2007).

Drama therapy and attachment. Weber and Haen (2016) connect drama therapy and attachment theory through links found in "attunement, self-regulation, positive emotion, state dependence, and narrative" (para. 12). Weber and Haen (2016) conceive of attunement as play-ing a role both in the up-close emotional perception of a client, but also in the way the therapist

uses a broader understanding of a client's needs in terms of activity, choice, and space layout. Weber and Haen (2016) suggest that drama therapists may have an advantage in facilitating attunement and subsequently a feeling of safety "because theatrical training serves to sharpen awareness of, and command over, the voice and body. In particular, the ability to modulate one's vocal tone, volume, timing and phrasing is a little-discussed clinical skill that can positively impact attunement" (para. 27). Attunement is also the mechanism used to inform choices around distancing, which facilitates brain integration and self-regulation (Weber & Haen, 2016). Drama therapists use distancing to bring their clients towards heightened feeling states or increased objective observation (Landy, 1996). Often the goal is aesthetic distance, which is the place where the two extremes can live side-by-side and cognitive/reflective and feeling states are both present (Landy, 1996).

Webber and Haen (2016) note a number of theorists who point to the positive side of attunement: Stern (1985), Hughes (2007), Schore and Schore (2008), and Nelson (2012). Not only does attunement of negative or hard emotions create connection, so too does the attunement and engagement around what could be seen as playful emotions, those of joy, laughter and positive feelings.

Emunah's Five Phase Model

Dramatic play. Rene Emunah (1994) proposes a 5-phase model of a group drama therapy process. In the first phase, Dramatic Play, the group is introduced to a "non-threatening, playful environment" where they participate in theatre games, improvisation and interactive experiences that are social and physical (Emunah, 1994). In this foundational stage, the therapist uses a strength-based treatment plan so as to build ego-strength in their clients and trust in the group as a whole (Emunah, 1994). Emunah recommends a more structured approach to this first phase if the group shows "reluctance, fear and self-consciousness" (Emunah, 1994, p. 36).

Scene work. Phase Two of Emunah's (1994) five phase model is Scene Work and focuses on improvised theatre and uses many of the structures of a theatre workshop but still maintains the goal of a therapeutic experience. In phase two, clients play characters other than themselves and tell stories that are different from their own life, thus giving clients a space to step outside of

their own story and character and in play "be different" (Emunah, 1994, p. 37). The therapeutic focus of this stage is on self-expression and exploring new ways of being, with little or no direction from the therapist to encourage processing of content; Emunah (1994) suggests this processing may happen spontaneously as the group moves forward.

Role play. Phase Three focuses on Role Play and deals with experiences and interactions taken directly from the clients' lives; if a group shares similarities, these often emerge in the scenes presented (Emunah, 1994). Group members can play themselves or have others play their role in a scene, thus allowing for participants to reflect on their own and others' choices and behaviours which facilitates development of the 'observing ego' (Emunah, 1994). In this stage, the therapist must help group members find a distinction between scenes that offer practice for life, and those which offer catharsis but portray choices that would be less advisable to act on in the real world (Emunah, 1994).

Culminating Scenes. As phase three opens up introspection for group members, there is eventually a shift to the examination of life events, which have left a lasting impact on members and affects their life today (Emunah, 1994). Emunah's fourth phase is Culminating Scenes, wherein an individual re-enacts important moments in life, gives space for a group member to physically re-experience their life, which can lead to catharsis; a feeling of being understood, empathized with and witnessed (Emunah, 1994).

Ritual Phase. Emunah's five phase model culminates with the Ritual Phase, which offers group members space to reflect on the process they have been through, celebrate their growth and accomplishments, and name openly the paradoxical feelings of joy and sadness that arise from endings (Emunah 1994). Emunah (1994) points out that the ritual phase happens at the end of a series of sessions, but also at the end of each session, and it helps with the closure and transition from dramatic life into real life.

Theraplay

Theraplay is an attachment informed system of therapy that seeks to improve a child's inner working model of themselves and to build a client's capacity to relate to others and experience the safety and sustenance provided by secure relationships (Booth & Jernberg, 2010). In its orig-

inal form, Theraplay is delivered by a therapist who works with a family to help both child and parents experience their relationship in a new and positive way (Booth & Jernberg, 2010). It is also used in group settings where, in addition to main goals of improving self-esteem and the ability to trust others, group Theraplay "strives to increase the sense of connection and belonging among group members" (Rubin, 2010, p. 496).

First developed in 1969, Theraplay is deeply influenced by the work of Bowlby and is one of the original attachment informed treatment modalities (Booth & Jernberg, 2010). It uses playful "here and now" interactions to enhance a parent-child attachment bond. Theraplay seeks to provide children with a "responsive, attuned, empathic and reflective" experience (Booth & Jernberg, 2010, p. 28).

Theraplay aims to improve the relationship between two people, this dynamic is the focus of treatment (Booth & Jernberg, 2010). Theraplay uses structured activities to provide children with attachment experiences that build relational capacity and self-belief (Booth & Jernberg, 2010). Dafnay Lender (2006), Training Director of The Theraplay Institute, writes that theraplay helps children's attachment, not because of the activities themselves but because those activities allow for connection, during which, the therapist 'leads' the child and helps them 'organize' their inner world.

"Theraplay is guided by the adult" (Booth & Jernberg, 2010, p. 27). This guiding involves increasing, decreasing and maintaining a child's rhythmic, energetic state (Lender 2006). The theraplay therapist, like a parent, use "appropriate levels of touch, rocking, feeding, humming, changes of voice tone, tempo of movement, and facial expressions" (para. 3) to attune and connect; meeting the child at their level of intensity and then, through that connection, using structuring and containing to help the child regulate themselves (Lender, 2006).

Theraplay relies on the innate human capacity for responsiveness that leads to social communication (Booth & Jernberg, 2010). Two main facets of this capacity to connect are "(1) the ability to enter rhythm, synchrony and resonance, and (2), the ability to imitate and understand the intentions of others" (Booth & Jernberg, 2010, p. 44). Theraplay understands that anxious children can have difficulty with synchronizing and understanding intentions in others, and

so, uses the skills of the therapist in these areas to support growth towards that end (Booth & Jernberg, 2010).

Theraplay aims to provide children with attachment experiences that leave them with a positive template of connection, which offers the child's developing brain the chance to develop new positive, implicit schemas around attachment (Lender, 2006). By staying connected and responding to the needs of clients, the therapists help build the child's capacity to regulate their own emotions (Booth & Jernberg, 2010).

Now moments. "Theraplay is playful" (Booth & Jernberg, 2010, p. 28). Play is infectious it creates a feeling of being together, and "is essential to the development of a zest for life and energy for engagement in all children" (Booth & Jernberg, 2010, p. 28). This togetherness crystallizes from time-to-time into a moment of meeting, or a "now moment"(Booth & Jernberg, 2010, p. 49). Theraplay seeks to create moments of surprise and novelty, which engages a child in "a dyadic state of consciousness" (Lender, 2006). These moments can be energetic, full of surprise and laughter, or deep, calm almost zen like (Lender, 2006). The power of a now moment is that it offers the potential to a new way of relating and "new forms of internal organization" (Tronic et al. 1998, in Booth & Lindaman, 2010, p. 49).

The reflective function. Theraplay emphasizes attunement between therapists and client, caregiver and child; children learn about their own emotions through attuned reflection from a caregiver (Booth & Lindaman, 2010). As children learn about their own emotions through reflection, they also begin to be able to understand others as well (Booth & Lindaman, 2010).

Theraplay provides reflections but avoids providing interpretations (Munns, 2009). As children react to the activities and interactions in the session the therapist names and connects feelings to events directly preceding the emotion (Booth & Jernberg, 2010). Empathic reflections can help a child regulate in the moment and also build the ability to self-regulate (Siegle, 2006, in Booth & Lindaman, 2010).

Theraplay groups. The Theraplay Groups use an opening and closing ritual to structure their sessions, starting with "Check Ups" and finishing with "Food Share" (Rubin, 2010, p. 501). Group Theraplay uses four rules to help structure the activities; no hurts, stick together, have fun,

the leader is in charge. These rules are both stated openly and modelled by the leaders behaviours (Rubin, 2010).

Rubin (2010) states that,

Perhaps even more than in individual Theraplay, you must provide clear structure and strong guidance for the group sessions. This means that you and your co-leaders plan the activities and decide such things as when to start and stop, where participants will sit, and how to handle whatever occurs. (p. 497)

Rubin (2010) suggests some adaptations for groups comprised of children who have difficulty focusing, present anxious behaviours, or have "more serious psychological difficulties" (p. 504). Children presenting these issues should be treated with shorter sessions, and increased adult to child ratio (Rubin, 2010).

Group Theraplay conceives of a group's progress in a three-phase model; beginning, middle, and termination. In the beginning phase "You should introduce the group members to the rules, ritual and atmosphere of the theraplay group. It is during this stage that they learn how you expect them to 'be with' each other and how you will 'be with' them" (Rubin, 2010, p. 506). The middle phase of Group Theraplay builds on the trust and sense of safety created by the beginning phase. The middle phase moves from the nurturing and structuring domains into the challenge domain, which offers more 'exciting' activities. Children are helped to build comfort around eye contact, touch and closeness, trust, turn taking, cooperation, managing excitement and facing challenge (Rubin, 2010). The termination phase is used like most therapy groups, wherein you are preparing the clients for the end of the group, looking back on past fun and success, and cementing memories of the time together (Rubin, 2010).

One adaptation of the theraplay model is the Sunshine circle. The Sunshine circle model was developed for use in schools, it is administered by teachers and assistants and does not provide therapy per say. The activities "lead to greater respect for each other, more confidence, more connection to each other, and the ability to cooperate and solve problems" (Rubin, 2010, p. 514). In a recent study, Tucker et al. (2017) administered the Theraplay group model, Sunshine Circles, to groups of at-risk preschool students. The study showed that the application of the Theraplay

model improved areas of social and emotional competencies, and overall classroom behaviour (Tucker et al., 2017). Children in the study who had received the treatment condition also had statistically significant improvements in areas of anxiety, aggression and hyperactivity, as well as fine-motor skill development and emotional regulation (Tucker et al., 2017).

Theraplay and Polyvagal System. The ability to co-regulate emotionally is dependent on the physiological functions of neural connections between the face and heart (Porges, 2015). "This face–heart connection forms an integrated Social Engagement System that provides and senses signals of safety" (Porges, 2015, p. 118). The actions of the Social Engagement System are intimately connected to the Theraplay method as "Theraplay is geared to the preverbal, social, right brain level of development" and focuses on "face-to-face emotional communications involving touch, eye contact, rhythm" (Booth & Jernberg, 2010, p. 26). With connection established, a therapist can use "facial expression and voice to calm the physiological state" (Porges, 2015, p. 117).

In some situations, and with some individuals, it is harder to access the Social Engagement System because a state of mobilization (fight or flight) impedes social cues of calm and safety and those cues may be misinterpreted as threatening (Porges, 2015). If an individual's fight or flight systems are engaged due to an actual or perceived threat, the Social Engagement System is dampened (Porges, 2015).

Theraplay seeks to increase an individual's ability to experience an 'up regulation' without deactivation of their Social Engagement System by engaging individuals in exciting, playful activation while at the same time maintaining face-to-face regulating social connection (Lindaman, 2016). The choice and sequencing of Theraplay activities also helps to regulate individuals by moving them through a cycle of "social engagement, play, and the down regulation of arousal by nurturing care" (Lindaman, 2016, para. 9).

Theraplay and the Neurosequential Model of Treatment.. Theraplay draws links between their approach and that of Bruce Perry (Munns, 2009). Bruce Perry's (2009) Neurosequential Model of Treatment (NMT) and Theraplay both recommend starting treatment at the earliest impacted developmental level (Munns, 2009).

The NMT is an assessment and intervention model which uses the current understanding of neuroscience in order to understand the neurological impacts that trauma and maltreatment have on a child's developing brain (Perry, 2009). "There are three central elements of the model: a developmental history, a current assessment of functioning, and a set of recommendations for intervention and enrichment that arise from the process" (Perry, 2009, p. 249).

Developmental history. When inquiring about a child's developmental history the NMT model seeks to discover the effects that trauma and neglect has had on a client by learning about the "timing, nature, and severity of developmental challenges" (Perry, 2009, p. 249). As attachment plays an important role in shaping a developing brain, the NMT assessment also seeks to learn about a client's early attachment experiences (Perry, 2009). These relationships could indicate areas of developmental trauma but also may show the possibility of resilience and positive developmental milestones.

Current assessment of functioning. The second stage of the NMT model is an assessment of current function and a hypothesis about the brain areas that are working, developing or undeveloped (Perry, 2009). This current assessment requires a multidisciplinary team and a senior clinician who has a broad range of skills in the areas of "child development, clinical traumatology, and developmental neurosciences" (Perry, 2009, p. 250). Unfortunately, the clinical requirements of this model make it difficult to broadly apply the method (Perry, 2009).

The intervention structure of the NMT system often referred to as 'bottom-up' because "Simply stated, the idea is to start with the lowest (in the brain) undeveloped/abnormally functioning set of problems and move sequentially up the brain as improvements are seen" (Perry, 2009, p. 252). Treatment begins with building capacity around "self-regulation, attention, arousal, and impulsivity" which is treated through the use of physical and rhythmic activities (Perry, 2009, p. 252). Once this regulatory system has been strengthened, the next steps are to build social relational skills and then to move to a cognitive insight-based form of treatment (Perry, 2009).

Theraplay domains. Theraplay has identified 4 main interactive styles that generally cover all relational interactions a child and parent participate in. These are engagement, structure, nurture, and challenge (Booth & Jernberg, 2010).

Engagement: "Peek-a-boo, I see you." Engagement is a playful back and forth that honours both participants' sense of self and autonomy (Booth & Jernberg, 2010). In early life, engagement activities include eye-contact and baby talk which leads to the building up of an energetic dynamic between the two participants. The parent is always looking to engage at the appropriate level and maintains awareness of the child's need to cool down or take a break (Booth & Jernberg, 2010). Engagement teaches the ability to "have fun together" (Munns, 2009, p. 29). Theraplay seeks to use encounter activities to experientially build a child's belief that they are, in the eyes of the other, a worthy and valuable person, who is able to "interact appropriately with others" (Booth & Jernberg, 2010, p. 23). These experiences show a child that surprise and novelty can be positive (Booth & Jernberg, 2010).

The therapist builds rhythmic and relational connection with the child using "simple pre-verbal, physically interactive play" (Lindaman & Lender 2009, p. 60), like chasing, and touch. In a group setting this might be a game of freeze tag or the creation of secret-hand-shakes. The therapist also draws the child's attention to their "special attributes" by pointing out specific things about the child's body and person that the therapist appreciates (Lindaman & Lender 2009, p. 60). Engagement is also created by "joining with positive emotions and 'amplifying them,' and connecting with negative emotions and offering soothing" (Lindan & Lender, 2009, p. 60). Engaging activities are very important for children who are internalize their pain, are defended, isolated and seek safety through control and rigidity (Booth & Jernberg, 2010).

Structure: "Red light, green light." Structuring is key for children who are "overactive, unfocused, or easily overwhelmed; it is also central to helping children who have an anxious need to be in control" (Booth & Jernberg, 2010, p. 22). The more dysregulated a child is, the more calming and structured the sessions will need to be (Munns, 2009). However structure is not punitive or aggressive. "Structure is not about control, but rather about conveying a comfort-

ing sense that someone bigger and more capable can make the world safe and predictable" (Booth & Jernberg, 2010, p. 22).

A key component of the theraplay approach is that it is "guided by the adult" (Booth & Jernberg, 2010, p. 27). Like a confident parent, the theraplay therapist leads the group (Booth & Jernberg, 2010). In the early life of a child, the parent provides for all the needs of the child. The Structure domain mimics this early process of attachment where the parent handles the needs of safety, comfort, and initiating playful activities, which "organizes and regulates" a child's experiences (Booth & Jernberg, 2010, p. 21). Structuring provides boundaries for a child and leads to the ability to self-regulate (Booth & Jernberg, 2010).

Nurture: "Rock-a by baby." Nurture is the flip side of the coin to the structure domain, and these two domains must be applied in equal weight when providing Theraplay (Buckwalter & Finlay, 2009). Theraplay defines nurturing activities as those that offer "reassuring, calming" comfort (Booth & Jernberg, 2010 p. 24); activities such as feeding, rocking, cuddling, rubbing lotion on 'boo-boos.' Nurturing can also be accomplished by noticing and commenting on an individual child's 'special traits,' such as a great laugh, beaming smile, strong muscles, or kind helping of a friend (Munns, 2009). With older children this "noticing of special traits" may be perceived as forced or disingenuous if done as a specific opening activity, as is often done in group theraplay, however, by providing this noticing and appreciating throughout the session based on actual observable behaviours, older children have an easier time accepting this type of praise (Gardener & Spickelmeir, 2009). By providing nurturing for a child, eventually the child internalizes this behaviour and is able to nurture themselves (Booth & Jernberg, 2010). The main goal within the nurture domain is to reassure and comfort the child (Booth & Jernberg, 2010).

Challenge "You can balance two… lets try three?" The Challenge domain of theraplay seeks to provide children with a "developmentally appropriate risk" (Booth & Jernberg, 2010, p. 25) so that the child can practice the experience of being slightly unsure, or afraid. As the child ages, these challenges increase in complexity; as the child gains competency, the child is aided in internalizing this positive feeling of success (Booth & Jernberg, 2010). In a theraplay session, careful consideration is used to find activities that lead to experiences, which lead to a likely

feeling of success (Booth & Jernberg, 2010). Challenge helps a child build self-confidence and teaches a child how to strive towards their full potential (DiPaswuale, 2009).

Chapter 4. INTERVENTION

Key Components

The following intervention is designed to facilitate group cohesion in hard-to-treat youth who have various traumatic and attachment related impediments to participating in a group therapy process. A suggested therapist script is marked in italics.

Structure leads to safety. Key Components of this intervention are structure and safety. Gaskill and Perry (2014) say that the 'key to treatment' is two-fold: firstly, the client must be regulated, they must feel safe, and secondly, "relational and cognitive expectations" (p. 186) must fit that child's abilities. Structure is key to creating a contained sense of safety (Leichtentritt & Shechtman, 1998). Easily dysregulated children work best when "limits are very clear, goals are manageable and the children themselves feel contained and nurtured" (Aronson, 2012, p. 597).

The first component of structure is that the therapist must lead (Booth & Jernberg, 2010). This requires having a clear plan for the session and a confident relaxed approach to delivering that plan. Even though there can be a need to change the direction of a session based on how the group is feeling in the moment, for instance if the group is overly excited or agitated, a session plan that focusses on engagement and challenging activities might need to be shifted to a more structuring, nurturing program. These shifts of plan should be confident and calmly implemented.

Limit testing. Sometimes children will limit-test seemingly small instructions. For instance, if their therapist gives the instruction "*Everyone have a seat and take one scooch backwards,*" a group member might stay standing while everyone else sits, or they might 'scooch' all the way back until they hit the wall. These small tests must be seen and contained. Small instances of not following the rules can easily lead to bigger limit testing. With every instruction, clear expectations must be expressed, and compliance must happen before moving on. This cre-

ates a sense of safety for the group and individuals. I think a child is asking, 'does he see me and does he care if I try to lead?' The answer needs to be 'yes I see you and no I won't let you take control. I've got this.' Even though these small limit tests seem like a joke they must be contained.

The first step at correcting a child who made a 'joke-like' misinterpretation of the instructions is to make clear eye contact and raise a kind but questioning eyebrow; this moment of engagement might be enough to help the child follow the rules. If they continue to limit-test, the therapist then looks at the group members who have chosen to followed the rules and thank each child who has done so. This shows the limit-tester that you see them and it gives the limit-tester time to choose to comply without having to be corrected: *"Jane is still in the circle, Steve scooched back one scooch, Andy is ready to do the next activity."* If the child still chooses to stand or sit by the wall once you've praised the other group members the next step is to directly ask the child to join the group: *"Paul I said one scooch, please join the rest of the group in the circle."*

The therapist must carefully blend positive, nurturing energy with strong clear limits (Shechtman, 2016). As a general rule, during the early stages of a group, the therapist must kindly let nothing slide: the emphasis here is on *kindly*. For the first month, make sure instructions are followed and do not move onto the activity until the group is ready. One can always take a step back from strictness but trying to establish it with a group that has taken control from the therapist is much harder.

Structured social interactions. Another way to increase the group's feeling of safety is to maintain a high level of structure around social interactions. For most of the sessions the group is not going to be given free rein to choose partners or work collectively. The therapist will play a very engaged role in helping scaffold positive social interactions. These clients can easily slip into aggressive and bullying type behaviours. This can be the result of an old social pattern or as a defensive need to soothe their current stress. However, by allowing an individual to judge, tease, or in some way belittle another child, all group members, including the one being aggressive, feel unsafe. "…forestalling destructive criticism and attacking behaviour must be a primary concern" (Dumais, 2016, p. 34). Micro-aggressions like eye rolling, tongue tisks, and snorts need

to be addressed and stopped. It is best in the first stages when trust is still being established to avoid calling out a specific person: instead, make a general rule to the group.

> *Therapist: So, I think I just heard a (repeat the 'huff' noise). If we (make the noise) or (tisk tongue) or roll our eyes (give over the top example). This is us saying with our body, 'ohhh the thing you did is dumb, you should stop.' That can hurt people's feelings and make them feel like they shouldn't be brave or share their ideas. So, from now on you might hear me say, no eye rolls, no (make scoff noises). OK let's keep going.*

If done from a place of caring and with a friendly tone the therapist can establish the norm that the therapist will correct people's behaviour, but that the correction doesn't necessarily lead to anger or exclusion.

Using the body to build self-regulation. As Bruce Perry's (2014) Neurosequential Model of Treatment suggests, this intervention begins with building capacity around "self-regulation, attention, arousal, and impulsivity" (p. 252) through the physical and rhythmic activities.

Self-regulation can be facilitated through the body. "Somatosensory activity such as walking, drawing, tracing the infinity symbol in sand, balancing side-to-side, drumming with one's fingers, throwing a ball from hand-to-hand, dancing, pushing against a wall, massaging oneself, diaphragmatic breathing, and other forms of patterned, repetitive movement contribute to state regulation" (Weber & Haen, 2016, p. 223). The following intervention begins with simple physical activities that are easy to master yet fun and engaging. The structure domain from Theraplay informs many aspects of the early part of the sessions. Many games that follow a start-and-stop structure like "red-light, green-light" where an adult starts and stops movement with a cue are used. These start-and-stop games up-regulates and then down-regulates the group using fast paced energetic movement balanced by calm pauses. They also build the habit of the group following the lead of the adult.

Social Engagement System. To compliment the use of physical activities to engage the body, the therapist will also use the social engagement systems to build a feeling of safety (Porges, 2015). This system is accessed by positive face-to-face interactions and soothing verbal tones. With connection established, a therapist can use kind, calm facial expressions and positive

tone and prosody of voice to help the group calm themselves (Porges, 2015). In the following intervention outline you will see that a 'sing-song or chanting' voice is used in a number of activities. This is an overt attempt at accessing the social engagement system and increasing the 'volume' of the therapist's soothing, positive social presence. Through tone and rhythm, the therapists verbal interventions show the group that they are seen and then helps the group shift the rhythmic energetic dynamic. This singing is also fun and silly, and aims to create a playful atmosphere in session.

Session Overview

This intervention is suitable for groups of children aged 7-12. The group should number between 5 and 8 participants. It is helpful to have an extra adult on hand who can act as an audience member and connect with individuals who choose to sit out and observe the process.

The intervention plan is divided into three phases. Phase One: Day One, First Impressions; Phase Two: Rhythmic Regulation; Phase Three: Structured Social Success and Scenes.

Phase One. As first impressions are important, I've included step-by-step plan for the first session with a script designed to show how the activities are introduced and conducted. The purpose of this first day is to introduce the group to the space, the form, and the expectations of the group. It also establishes the strong frame that is necessary to work with groups who are easily dysregulated.

Phase Two. The second phase of this intervention is highly structured. A strong container helps build children's capacity to regulate themselves through carefully administered activities, which raises the groups activation and then returns it to a manageable level. This excitement and calming is facilitated by the Therapist, who is providing engagement and structuring activities.

Phase Three. The third phase of this intervention aims to help the social, relational development of clients by working in pretend play, first in structured games, and then through Onoe's (2014) Improvisational Drama of Acceptance and Mirroring (IDAM). Onoe's (2014) IDAM is an adaptation of D. R. Johnson's DVT therapy. IDAM fits well with the developmental needs of this population. It helps a child feel like their inner world is perceivable and respected by an adult, it fosters a sense of pride in their own creative abilities and pride in being witnessed by their peers as funny, creative, and brave. This third phase also works on more advanced social

skills. By having to sit as an audience and watch scenes, children practice containing their excitement, turn taking, giving feedback in a positive way, and self-regulation. The audience is also gaining benefit by watching their peers create and play. This observational learning has therapeutic benefit; as witnesses, they can vicariously experience the therapeutic benefit of these scenes (Jones, 2007).

Phase One: Day One, First Impressions

The therapeutic goals of this phase are to provide the structures that allow for a smooth transition into a new experience; establish norms of safety and respect and the holding nature of the therapist's stance; and provide each individual with an experience of success and a feeling of being seen.

Introducing the space. To begin, I have found that it is best to establish a line up outside the door of the therapy room before entering the space. This line is a place to give your first instructions so that the children enter the room and don't need to be gathered together and told the plan. Each session should start this way.

> *Therapist: Hello my name is Bill and this is our first time doing Drama Therapy. In a little while we'll talk about what this group is and why we're here, but the first thing we're going to do is enter the room and sit in a circle. So we'll walk in, safely, and find a spot in the circle. Then I'll explain what our first game is.*

Open the door and allow the children to enter the room. If they run and push, notice this, and, in a sing-song voice, start to establish safety norms. The use of the sing-song voice is surprising. It aims to side step any existing relational expectations these children may have about authority figures. The sing-song voice also allows for repetition of instructions without it seeming like one is 'badgering'. The sing-song voice is silly and playful, while at the same time the content is firm and structuring. It is the first message to the children that you are going to be a 'different' kind of person than they are used to. It models bravery and comfort with being playful. Singing/chanting like this does require a slight cocked eyebrow; the therapist needs to show with their eyes, 'I know this is silly, we're both in on the joke.'

> *Therapist: We're heading for a circle. Making for the circle, I'm on the edge, join me here. Here in the middle we'll all find a spot, sitting in the circle, believe it or not. There's*

two in the circle, now there's three in the circle. We're here and ready we'll get started when we're here. We're waiting on Thomas, he's looking at the cupboards, he's looking at us and he's moving this way. Here we are.

Activity 1: Sticker Hunt. Before the session the therapist has hidden a large number of stickers around the room. Developmentally, this activity can cover a range of abilities, depending on how difficult one makes the hiding spaces. I find a range from very obvious to almost impossible to find works well for a mixed group. The key is to hide a huge number of stickers so that there are at the minimum ten stickers per participant, even more is better. All activities should give the children an experience of success.

Therapeutic Goal. This activity gives the children a chance to explore the room, assuage their curiosity, and make sure they are in a safe place. Peter Levine's (1997) orienting is a method to calm the nervous system by taking in one's surroundings. The introduction of a simple activity starts the group off with a game that many children already know how to play: this connects to Redl and Wineman's (1965) idea of using "neighbourhood codes" to help children participate in following rules.

- Theraplay domains: Engagement, Challenge.
- Drama Therapy Core Process: Play, Embodiment.

Therapist: So every day we'll start in the circle, there's room for everyone. Since this is our first day and you haven't been here in this room before, we need to check it out, look around. This is like a treasure hunt, but today the treasure is stickers (hold up an example) like these. I've hidden lots around the room. I bet you'll all find a few each. Stick them on your hand and remember one of your favourite hiding spots. Have fun, stay safe, go find some stickers.

Reflecting and tracking. As the group scatters around the room stand in the middle and start to call out names, places and feelings (Booth & Jernberg, 2010). *"Tom is curious about the cupboards, Allison is exploring the sink, Dave is getting low down by the heat rad, he's really focused."* This type of reflection happens in a number of activities, the kids might look at you and smile, they might give you a quizzical look, they might ignore you. What ever their response is, the goal is to create a sense of 'us.' You are seeing the individuals and creating a group identi-

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ty. This reflecting also falls under the Theraplay domain of Nurture as you see and name a child's individual contribution to the room.

As the children explore the room there may be some disagreements over territory and individual stickers. You can carry extras with you and most tussles can be broken up with a direct *"no pushing, there are lots more to find. Tom take a look left Jim take a look right. Good teamwork, thanks for listening."*

When most of the stickers have been found, check that all children have at least two or three stickers. If someone hasn't found any, you didn't hide enough. Call the group back to the circle. *Therapist: Alright gang, lets come back and tell each other some cool hiding spots we found. Can everyone hold up their hands.*

Go around the circle and have each child share a cool spot. This establishes turn taking and listening. It also shows each child that their own experience is important to the group and we want to hear from them. The therapist may need to be clear on these expectations as the sharing moves around the circle. It is important to establish norms of behaviour from the very beginning. *"Let's listen when others are talking. Taking someone's turn is taking something away from them."* You may also need to keep a child from explaining every sticker's hiding spot. *"Pause pause, (Pause is a more positive word than STOP) I know you found so many cool spots, but I want your favourite, just one."* This over-sharing could be an impulse control issue or a limit testing of the 'choose one' instruction, either way, establishing your structuring and holding is key here:

Therapist: Thanks for sharing all your cool hiding spots. Next we're going to talk about the rules for drama therapy.

Activity 2: Group Contract. The therapist produces a large poster with three words written on it: Confidentiality, Safety, Bravery.

> *Therapist: Has anyone ever made a list of rules in a group before? We're going to make some for this group. First off, this is therapy so we have a thing called confidentiality. Does anyone know what that is? What we say and do here is private, we might talk about our feelings or our fears or things that have happened to us, and those are stories that should be respected. You can tell your story but you're not allowed to tell other people's*

stories. The only reason I talk about the things that happen here are if someone is being hurt, I have to tell, and also I talk to my boss so that I can learn and get good advice on being the best therapist I can be. Other than that, the stories stay in this room. Anyone have any ideas or questions about confidentiality?

The group converses.

Therapist: The next rule is Safety. Safety means, our bodies are safe, the room is safe, and everyone's feelings are safe. Safety and respect kind of work together. If I respect my body, I keep it safe, if I respect the room, I don't break things. If I respect the other people here, I keep their feelings safe. Anyone have any ideas or questions about how we can stay safe?

The group converses.

Therapist: The other rule is Bravery. I'm going to ask you to do things, that maybe you don't think you can do, all I ask is that you be brave and try. You always have a right to take a little break; if things get a bit too much, you can go sit next to the wall and watch and feel better. And you're always allowed to join back in. Anyone have any ideas or questions about Bravery?

The group converses.

Therapist: Kind of like putting your signature on a contract we're going to put our stickers on the piece of paper where we wrote our rules.

The group puts their stickers on the paper. Some children may want to keep the stickers. If this is the case, provide the children with an extra piece of paper and direct them to put half on the contract and half on their take-home sheet.

Therapist: One more thing I should say before we get started is, you're allowed to take a break here. Sometimes we all feel a bit overwhelmed, maybe we're tired, or we've had a bad day. Maybe you're getting a bit too excited and having a hard time calming down. Here in drama therapy, you are always allowed to take a break and sit on the side and watch. You're always allowed to take a break and join back in when you're ready.

Taking a break is a good option for when an individual needs to take a moment to regulate but the rest of the group is still able to function well. Continue to check in with the individ-

ual, and as activities transition, ask if they would like to join back in. Don't forget about this member even though they are participating by watching.

Activity 3: Do the impossible and receive praise.

Therapeutic Goal: This activity establishes a playful, silly atmosphere and broaches the subject of pretending, respect and bravery.

- Theraplay Domains: Engage, Nurture, Challenge and Structure.
- Drama Therapy Core Process: Embodiment, Personification, Witnessing.

  Therapist: Everyone stand up…. Stretch up, reach down, wiggle your fingers, stand up tall. Here we are. So, in Drama Therapy I'm going to ask everyone to do impossible things. I might say 'Be a cat, climb a mountain.' But we're not cats, we don't have a mountain, but we'll pretend and try our best. Sometimes pretending can make us feel silly, or maybe worried, so it takes Bravery. It's not always easy to be brave, so when we're brave we deserve to be complimented. So now, one at a time, I'm going to ask you to do an impossible thing, and then we'll go around the circle and each person will give the person who is pretending a quick compliment. It can be a thumbs up or you can say 'good job' or anything nice. We'll start on my left. Please, with your body, show me the colour blue, Don't point to it, be it. It's impossible but you can do it.

Whatever movement or shape the child makes, the therapist replies 'perfect,' and then cues each child to give a quick compliment. Each child is asked to 'with your body show me…the ocean...a tree in the wind…an empty box.' As they take the shape, the therapist says 'perfect' and then makes each person say a compliment to the person making the shape.

The activity comes to and end.

Therapist: Take a seat please. Take one scooch backwards.

Activity 4: Straw Balance

Therapeutic Goal: This activity gives children an experience of success and allows them to work with trying and succeeding, and trying and failing, in a fun way with low stakes. This balancing game is physical but requires concentration. This game is also a together but alone game. Each person is working on their own but everyone is doing the same thing. During the ac-

tivity the therapist actively tracks and witnesses the children. Calling out names, feelings and actions.

- Theraplay Domains, Challenge, Nurture.
- Drama Therapy Core Process: Play, Embodiment.

Prior to the group, the therapist has created a number of 'long straws' by crimping the end of a straw and sticking it an inch or so into another straw. This is repeated until the long straw is five or six straws in length. Create enough of these long straws for everyone in the room to have one and make 2 or 3 extra just for safety sake. You will also need a pile of napkins or paper towel. By draping an unfolded paper napkin over the end of the long straw you create an object that is very easy to balance on an open palm or tip of a finger. Don't squeeze the napkin tight, leave it draped open over the top of the straw.

Give each child a straw and napkin and then demonstrate how to balance the straw and napkin on your open palm. Some kids will rip the napkin, give them a new one. Some kids will separate the straws, trade them a fixed one or fix their broken one. This care falls under Theraplay's nurture domain and can start to establish trust in an adult to fix problems. You can also show a more advanced child how to fix their own straw, if you see this type of problem-solving compliment it loudly for the group to hear.

As the group starts to explore the balance of their straws and explore their body and the room, I use a slightly chanting style of the sing-song voice. Something rhythmic that fills the air with your noticing. This tone can be created by holding the last word a bit longer than would be normal.

Jill is balancing on her fingerrrrr.

Abbey has it on her palmmmmmm.

Steve is seeing how fast he can gooooo. His eyes are shininggggg,

Tom picks his stick back up, good job being brave.

If you see a child invent a game call it out and see if the other kids will play along.

Tanya is trying to go from wall to wall. Can anyone else touch one wall and then the other without dropping their straws?

At the end of the activity, collect all the straws and napkins. If children want to keep them say

"I'll hold onto these, maybe we'll need them again, but if you come across some straws you can make your own"

Activity 5 / Closing Ritual: Cookie and Crumb.

Therapeutic Goal: Cookie and Crumb models and facilitates sharing of feelings, it also shows the group that there is space for positive and negative feelings.

- Drama Therapy Core Process: Witnessing and Ritual.

- Theraplay Domains: Structure, Nurture, Engagement.

To close each session we return to sitting in a circle.

Therapist: Here we are at our last thing for the day. We'll always end this way, sitting and doing cookie and crumb. Remember we're taking turns, each person gets to use their time. We'll start on my right and go around. I'd like to hear your cookie, that's the sweet part, the positive part of the day; and, the crumb, the crumb is crummy, you don't have to like everything here. So let's each share a thing you liked and a thing maybe that wasn't your favourite, or didn't like, from today's group?

As we go around the circle it is very important to stop children from talking over, or even suggesting things, in what appears to be a helpful way. These 'helpful suggestions' can be motivated by a genuine desire to help, a child's need to control a situation, or by impulsiveness. For the child being 'helped' it is taking away their autonomy and strength. "*Let Jane have her turn, if we talk when it's her turn we're taking something away from her.*"

The therapist should get the last word in cookie and crumb and say something positive about the group and something that is constructive. "*My cookie was; I loved watching everyone explore the straws, and my crumb was…well I don't think I have a crumb today*"

Phase Two: Rhythmic Regulation.

Therapeutic Goal. Section two focuses on building group members' capacity to regulate themselves through physical, rhythmic activities and social engagement. This phase of treatment might take as little as two weeks or it may make up the majority of all sessions. The therapist will judge when the group is able to move into phase three.

Structured games play a large part in this section of the intervention. As discussed earlier, when an individual chooses to follow the rules of a game, they are participating in "self-imposed

discipline" (Spolin, 2011, p. 401). Following the rules of a game is a type of self-regulation and by practicing this skill we increase an individual's ability to make choices about how they behave in the world.

Key Guidelines

1. The therapist is in charge.

2. Children work separately, but together. Either in a group activity, wherein each person has their own space, or in a one-on-one activity, where one person is working while the rest of the group waits and watches.

3. Limit-testing must be respectfully curtailed. Do not move forward unless the children are regulated and following instructions. If there is a break down during an activity and the group seems to spin off in a million directions, then the therapist must introduce calming activities that include slower physical activities, calming visualizations, or scaffolded verbal processing of why the group is having difficulty following rules and regulating. Theraplay's playful control is key in these situations. The therapist must be able to get the group to listen, when in doubt sit them all down and calmly talk while reflecting emotions.

Session Structure. Each session tends to have a similar set of activities, however, as the group progresses, the 5 activities that made up the entirety of day two will become a quick opener to build focus and energize the group. Once a group can accomplish an activity quickly, it only needs to be used as part of the warm up phase.

All sessions in phase two contain: Opening, Sound and Movement, Rhythmic Circle Games, Structured Movement Games, A Main Activity, Closing, Cookie and Crumb.

Activity 1/Opening: Sound and Movement: This opening will become the traditional opening of the group for the rest of the sessions.

- Theraplay: Engagement, Structuring.
- Drama Therapy Core Process: Play, Embodiment.

Therapeutic Rational: This game conveys the idea that, we as a group see you, engage with you, and however you are feeling, and however you choose to express that, is going to be honoured. Using an abstract sound and movement check-in asks clients to share a bit of themselves without asking for too much emotional vulnerability.

Therapist: I'd like to know how everyone feels, so we can start the group. Instead of telling us how you feel with words, we're going to use our bodies and a sound, not words though, a sound to show how we feel. If I tell you I feel (demonstrate a fast movement with sharp sound) or (demonstrate a slow fluid movement with a calm sound) you can make a good guess about how I feel right? The best way to learn about how someone else feels is to do the sound and movement yourself. Each person will make a sound and movement and then the group will repeat it back. It's a way of saying, 'I feel happy' and then the group acknowledges that feeling as if to say 'Oh you feel happy'. This won't be all your feelings, because we can be filled up sometimes even with opposite feelings but let's see if we can share a feeling we want the group to see. We'll start on my right with a sound and a movement, and then I'll count 1,2,3 and we'll all repeat it back at the same time.

It may take some time, even three or four sessions, for this activity to be the quick and easy opening that it is intended to be. The therapist should have a light, playful and accepting approach, welcoming all movement and sound, even if it is a slight shift of weight and a breath out this is what we reflect. Often the therapist says, *'thank you for showing us how you feel'.* In the first session I will let low volume, disengaged reflections happen, but I will curtail aggressive over energized reflections by saying "*aim to be exactly the same energy, same volume. If they say "blerp" we say "blerp," we don't scream "BLERP" because that's not how they feel."* Often exaggeration can feel aggressive, so the therapist needs to step in to protect the person who has just shared. On the flip side, under-engagement may be the result of shyness, which can be accepted for the first session, or it could be oppositional disengagement. In the second session, I start to cue for both over reflection and under reflection, and if I see either becoming a pattern for certain individuals, I will have the group repeat the reflection again. This shows that the therapist will not allow for the rules to be nudged towards being ignored. As always, this type of hard and fast rule should be gauged for each individual, and the therapist should use clinical judgement of when to set limits and when to allow a participant to engage at the level, and in the style, that they are currently able.

Activity 2: Circle games for energy or focus.

Zip Zap Zop. Zip-Zap-Zop is a familiar game to many theatre teachers, often it leads to elimination of those who fail at the pattern.

- Theraplay Domains: Structuring, Engagement, Challenge.
- Drama Therapy Core Process: Play.

With groups of hard to treat children, elimination leads to deep feelings of hurt and exclusion, so do not use elimination in a game.

> *Therapist (talking in a funny authoritative voice, like a general or an old-school European film director): When we play this game, if you make a mistake, there will be consequences. The three punishments, dun dun dunnnnn. I will tell you about them when we need them.*

This playful role of 'authority figure' helps show that the games are just games and that consequences from play are not dangerous.

The first round of zip-zap-zop is played. The therapist always starts, saying *'for our first game, we will play zip-zap-zop, charge your magic wands,'* these are clasped fists with the index fingers pointing outwards in a gun like shape, but for propriety sake, I call them magic wands. This first step of 'charge the wands' is about buy in, children can do it as unengaged or as enthusiastic as they want, but they must end up standing ready with their hands clasped and index fingers pointing out. If this doesn't happen, we re-cue and wait for everyone to show they are ready to play. The therapist points across the circle saying *Zip*, the person he pointed to chooses another person across the circle, points and says *Zap*, the person who was pointed to chooses another person across the circle and says *Zop*. The receiver of *Zop* chooses another person and says Zip, the game continues on like this. The energy and speed tend to build.

Therapist: Stay ready, face forward, knees bent, eyes bright. Follow the energy. You're using your ninja skills here. Quick, accurate, ready. If the game is going to slow say "*Don't hold the energy, it's a hot potato, if you hold it, I'll call you out.*" If someone holds the energy too long, or if someone inevitably flubs the *Zip-Zap-Zop* pattern the therapist introduces the 'Three Consequences.'

Additional Circle Games: Additional examples of rhythmic circle games include: Clap Focus, tossing a ball, clapping out a rhythm and having the group clap it back, traditional camp call-and-response songs like the song 'There was a Great Big Moose'.

The Three Consequences. Often children's games are elimination based; if you fail at a game you are sidelined and will watch the others play until there is just one winner. Elimination is positive because it creates stakes, which can make a game more engaging, however, for a group of easily dysregulated children, being eliminated from a game triggers deep hurt and can easily lead to a meltdown. For this reason, this intervention never uses elimination as part of a game. However, to create a feeling of stakes, we use a silly playful set of 'consequences' and offer three options, which facilitates a feeling of control for the children. One of the options is always 'nothing', the choice to not receive a consequence. It is important to use a silly, playful, authoritative voice to administer the three consequences. This broad distinction helps children understand that this is play and not a real punishment.

Therapist: Ah, a flub, a little mistake and so the consequences of (shifting into silly voice, a British drill sergeant or old-school European film director) the three punishments.

Would you like to (1) say three rhyming words, (2) do a little dance or (3)....nothing.

Whatever the person chooses, have them complete that quick consequence, thank them, and move right back to the game.

You might find that someone likes the attention of the consequences, if someone purposely keeps making a mistake in order to receive the consequence, you can add new choices to make it more challenging. Once the group is comfortable with the three consequences, I have found it helpful to include as one of the three a game called Emotional Charades.

Emotional Charades. If this consequence is chosen, the circle game pauses while the therapist gives the 'offending' child an emotion to act out. The rest of the group is actively involved in this activity as they are the ones who guess which emotion is being portrayed.

Therapeutic Rational: This game helps children practice both emotional expression and emotional comprehension.

- Theraplay: Structure, Engagement.
- Drama Therapy Core Process: Play, Embodiment, Witnessing.

Whisper a feeling or emotion to the player receiving the consequence and have him or her '*show us with your body what it looks like when..*' then the other group members guess. If there is energy around this, the zip-zap-zop game can be shifted into emotional charades, or you can alternate between the two games (Emunah, 1994).

Activity 3: Structured movement games. In the early stages of phase two, one structured game will be used. As the group gains skills and comfort, two structured games can be used. Below are two examples, but other structured games include, 'mother may I', 'what time is it Mr. Wolf,' or 'red-light, green-light'.

Flamingo, Seal, Cockroach.
- Theraplay: Challenge, Engagement, Structuring.
- Drama Therapy Core Process: Embodiment, Play.

Group members are asked to take some space around the room, spread out to find their own spot. The therapist shows the three shapes: Flamingo, standing on one leg with hands clasped in front to create a beak like shape; Seal, laying on your front with arms under the body; Cockroach, flat on your back with arms and legs held off the ground like a dead bug.

> *Therapist: As I say the name of the animal it's a race to see who can get there first. When everyone is in position, I'll call the next animal: Cockroach, 1.2.3.4.5, Flamingo, 1.2.3.4.5 Seal.1.2.3.4.5, Cockroach, 1.2.3.4.5 etc.*

As the pace of the game quickens, group members are moving faster and faster. They are getting used to following the therapist's directions and having fun while doing so. It is possible to alternate the rhythm so that the group has to move slowly or quickly based on the tone and rhythm of the therapists counting.

Upstage Downstage.
- Theraplay: Structure, Challenge.
- Drama Therapy Core Process: Play, Embodiment, Projection.

> *Therapist (in silly bossy voice): Alright friends, as this is DRAAAMAA therapy we will need to learn some theatre terms. I will now tell you the place names of the stage. Where the audience sits, this is called down-stage, it is the front. All the way back here, the back of the stage, we call this up-stage. When we face the audience over here, is stage-left and*

over here is stage-right. If you're facing the back wall, stage-left is still over here, even

though it's to your right, it's always stage-left. So now we will do a walking race. If I see

running, we'll have the consequences. (shifting back to normal voice). Walking race,

staying safe, up-stage (the group races), down-stage, up-stage, stage-left, down-stage.

Once the group is able to move on command, the therapist starts to add emotions to the location

directions. This step may take a few weeks to reach.

Therapist: Let's try up-stage Happy. What does your body look like when you're happy?

As the group moves, the therapist calls out movements and facial expressions he sees on indi-

viduals.

Activity 4: Main Activity. The point of a main activity is a way to begin exposing group

members in a safe way to performance and group interactions. The goal is for these activities to

be fun and engaging and to leave the group feeling as if they have accomplished something that

they can be proud of. The theraplay domain that is predominant here is Challenge. Main activi-

ties push slightly on the boundaries of what the group thinks they can accomplish.

Sculptures. Have each group member find a place to stand in the room. Demonstrate

Statues to them.

Therapist. We're going to become an art gallery full of sculptures, some of them will look

like people (show a pose), some like monsters (show a more monstrous pose), and some

will be pure shapes (show an abstract shape). As I call out different words, use your body

to make a piece of art.

Sculpture directives can be emotions, activities, professions, characters from books and movies,

and even objects (Emunah, 1994). As the group creates sculptures, walk through them and, using

an artsy voice, reflect back what you are seeing in a complimentary way. As the group grows

more comfortable over time it is possible to have half the group look at the sculptures, while the

other half stands as the sculptures.

Supplemental Main Activities

Character walks. This is a variation on the Upstage Downstage activity and will flow

well out of that warm up. Direct the group stand along one wall in a line. The Therapist calls out

a character or job description (e.g.. a proud person, a sad person, a police officer, a spy, a joker, a

scared person). Have each member walk across the room, one at a time, embodying this feeling or character. Reflect back choices you are seeing in their posture, rhythm and movement. Once everyone in the group has embodied the character or job or feeling select another and continue the game.

Therapist: Look at Toms legs, taking those big strong steps, that looks like a confident person. See how Jane has her head held high and her arms back, that looks like a super hero.

The Martha: This is a very popular game, and builds on the physical work developed in sculptures, but adds in a structured exploration of teamwork. Have the group start sitting in an audience position.

Therapist: We're going to make a picture together, a frozen image. One at a time each person will chose a piece of the picture to be, they will use their body to show us the shape and then they will use their voice to say I am (the thing). So, for instance, if I said 'forest' as our place, I could start by walking on stage holding my arm out and saying 'I am a tree', then I stay frozen. The next person comes up and maybe they would say "I am a nest" and use their hands to make the nest. The next person could say 'I am a bird'. And it keeps going until everyone is in the picture.

This game can be done with images of locations, jobs, buildings, or social settings. A fun variant is to do made-up movie posters. The therapist suggests a movie called, "The Angry Fish" and the group makes a movie poster for this title.

As the group builds comfort the next step of this game is for the therapist to walk into the picture and get each sculpture to speak one line.

Therapist: As I touch you on the shoulder I'd like you to say one word from the point of view of your sculpture. The Tree says? The Nest Says? The Bird Says?

If group members have trouble understanding this direction, the therapist can ask "what does the tree want?" or "what is the bird thinking?" This is a very safe and structured introduction to both teamwork and improvised scenes.

Phase Three: Structured Social Skills and Scenes

As the group moves through Phase Two, the therapist can slowly introduce games that require increased teamwork and theatrical skills. Phase Three will start when the therapist feels the group is ready to begin performing improvised scenes supported by the therapist. Phase Three contains a warm-up phase, which starts with Sound and Movement check-in, moves quickly through some circle energy games to some direction-following activities like Flamingo, Seal, Cockroach or Up-stage, Down-stage walks, and then heads into the second half of the session, which is comprised mainly of improvisation. About half of each session in Phase Three is spent with the group working in an audience type setting. After a few rounds of 'The Martha' to warm up the improvisational muscles, the therapist introduces Akeyo Onoe's (2014) Improvisational Drama of Acceptance and Mirroring (IDAM) (p.330).

Improvisational drama of acceptance and mirroring. Akeyo Onoe's (2014) IDAM is an adaptation of D. R. Johnson's Developmental Transformations therapy (DVT). "Developmental Transformations is a form of drama psychotherapy that is based on an understanding of the process and dynamics of free play" (Emunah & Johnson, 2009, p 89). DVT sessions are completely improvised and the therapist is not an observer or coach but involved directly in the play (Emunah & Johnson, 2009). The goal of DVT is to help a client loosen "…psychic structures that inhibit the client(s) from accessing primary experiences of Being" (Emunah & Johnson, 2009, p. 89). Johnson (2009) characterizes the role of the therapist, or 'player,' in DVT as being responsible for maintaining the 'play space.' The therapist's skill at being playful facilitates the client's playfulness, even in the face of discomfort (Emunah & Johnson, 2009). If the therapist perceives a situation or theme arising that seems to shut down the client, the therapist transforms the situation and facilitates play by uses their own "healing charisma" (Emunah & Johnson, 2009, p. 95). The therapist's job is to focus deeply on the client and respond to what is being shown by the client through "faithful rendering" (Emunah & Johnson, 2009, p. 96). Johnson likens faithful rendering to Rogers' (1951) system of "placing oneself in the frame of reference of the client" (Emunah & Johnson, 2009, p. 96). DVT has the potential to move deep into a client's material, however, at this point in the group, that is not advised. The goal of these IDAM

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improvisations is for the therapist's skill as an improvisor to facilitate success for the client; for the client's story to be respected and enacted.

In the context of this intervention IDAM is used as part of the overall session. After the Check-In, and Warm-Up phase the group is moved into an audience position, usually sitting on the floor leaning against a wall is the best option. This seating position has been used previously in games like *The Martha.* The improvised scenes tend to last 2-3 minutes and usually 3-4 individuals participate each day. It is very important to track who has participated and who has not yet taken their turn. I recommend not offering anyone a second chance before the entire group has had their turn.

The therapist should remember the client always wins in these scenes, they are the strongest, fastest, smartest characters, and the characters that the therapist plays is the most dramatic, over the top, fun and silly loser of ninja fights, the furious and clumsy parent who gets locked up, or the friend who joins in on the adventure. All the while the therapist comments on, and marvels at, the strength and skill of these amazingly powerful characters played by the clients.

> *Therapist: Take a seat in audience position. I'd like one volunteer to join me on stage and we will do some pretending together. (As a child joins the therapist on stage), let's have a round of applause for Sarah, and her bravery. So, Sarah, you and I are going to pretend, we're going to make up a little story or a scene, it'll probably take two or three minutes, and you get to decide what we do. You can say where we are, or who we are, or how we know each other, or we can just start and use our bodies and eyes to figure out what this story is going to be.*

There is no wrong way for the youth to act in these scenes. Onoe (2014) says she "accept(s) and mirror(s) each child's emotion and story as best as possible, while improvising a drama" (p. 33). If the youth chooses to say nothing, won't even respond to the question of 'where are we?' or 'how do we know each other?', the therapist still creates a playful atmosphere where this 'resistance' is used as an offer.

For instance, if the youth has chosen to stand silent and still in the middle of the stage, the therapist can still accept and play.

Therapist: HMMM it looks like you're standing very still, maybe you're a tree. Here, I'll try to chop you down (mimes chopping). "what? this tree has dulled my axe, maybe a chainsaw will work? (mimes chain saw). "jumpin' jillikers, the tree broke the chain saw? Maybe some dynamite? (comes out of character, engaging) Should I put it down at the bottom? What about here at the side?

The therapist treats the youth as if they are fully participating in the scene.

Therapist: Let's do a slow-motion explosion. I'll be the dynamite and you do the count down, when you say go, I'll explode.

These playful ways of trying to get the client involved might work or they may not; whatever happens, the therapist keeps moving forward with playful positivity.

Therapist: (makes giant, over the top, physical and verbal explosion) Wow, this is the strongest tree in the whole world nothing can move it. We fast forward into the far future, aliens are landing on earth. (becomes the alien)'Beeb Beeb Tree is very strong'. We go even further to the end of time, the universe is empty, the stars have fallen dark. As time itself winds to an end, one tree stands on a bit of rock that used to be the earth. Ok, we're almost done, how should it end? …Ok I'll figure it out. The tree, smiles, a single leaf falls (therapist mimes leaf), the leaf drifts through the galaxy, lands on another piece of space rock (therapist stands on the other side of the stage and grows into a tree mirroring the youth's body). The leaf takes root, it grows. Slowly, over time the strongest tree spread across the cosmos, bringing life, shade and strength to the ends of universe.

The therapist breaks character and steps forward into 'therapist' mode.

Therapist: (in an exaggerated presentational tone) Ladies and Gentlemen, that was 'The Strongest Tree', a round of applause please. Sarah, take a bow.

Scenes should last about two or three minutes, as the therapist feels the end approaching, a warning and structuring should occur. This pre-ending warning recaps the scene and asks the client how they want to finish, for instance.

Therapist (slightly stepping out of role). Ok so our ninjas have just had a huge battle of ice and fire blasts, this episode is going to end for the day. How do we finish?

The youth might say "One more giant blast" or "they just walk away." Therapist and youth enact the chosen ending and then the therapist directs the audience to applaud and the youth who has just performed to take a bow. This is very important, as it connects the audience and the performer, and encourages the performer to pause and receive appreciation for a job well done. In my experience this one-on-one scene approach works very well, the audience is engaged and looks forward to watching scenes as much as they do to being in them. In past groups when I have worked with Onoe's (2014) IDAM, it was the a favourite activity and the group would choose it over most other games.

In Onoe's (2014) original description of IDAM the one-on-one phase quickly leads into group improvisations where all youth are involved at the same time with the therapist in creating and performing scenes. In my experience the move to group scene work will take time. The structure and skills needed for a group of easily dysregulated children to work collaboratively will take significant time to develop. As the group grows in its ability to regulate and navigate social situations, more games and activities that require teamwork and understanding of another's perspective can be introduced.

Chapter 5. DISCUSSION

The goal of this intervention was to create a space that is safe, consistent and contained enough for easily dysregulated clients to participate in a group therapy process, which provides positive attachment experiences, moments of social success, experiences of relational competence, and pleasure in being with others.

As we have discussed earlier, structure is key to creating a contained sense of safety (Leichtentritt & Shechtman, 1998). Easily dysregulated children work best when "limits are very clear, goals are manageable, and the children themselves feel contained and nurtured" (Aronson, 2012, p. 597). The difficulty in maintaining structure for these clients is that often structure feels confining and possibly even punitive. It is easy for a strong behavioural approach to focus on the negative behaviours. For this system to work, structure must be balanced with nurture (Shechtman, 2016).

This intervention is designed to inspire other drama therapists and help them conceive of group processes that will support clients who struggle in a group setting. This structured approach may seem a bit heavy handed, especially for free-spirited drama therapists. However, by being overly open and permissive, negative patterns of behaviour can arise in clients and lead to guilt and hurt feelings. A therapist needs to protect clients from themselves and others.

This approach can be applied to any group process but the movement towards more freedom and unstructured activities will happen quicker with a non-traumatize group of children. Working towards this free and creative play is the goal and the therapist should always be checking to make sure that activities are challenging enough for the groups current developmental level. If the group can work together well and is able to navigate the complex social needs of a group creative process then it would be appropriate to move into a different therapeutic approach to address the current needs of the group.

For easily dysregulated children suffering from trauma or neglect this group process offers clients the experience of being a 'normal' kid. This group is a chance to play, and to complete a game without it coming to tears or blows. This group is a space where a child is appreciated for their creativity and for simply being part of the group.

As this intervention is meant to facilitate the movement of a group through the first two phases of a group treatment process, namely, orientation and then conflict, and its end goal is the development of cohesiveness and a "mature work group" (Yalom, 1995, p. 294). If this intervention is successful, the group will eventually be able to work in a more free, self-directed mode. In a Drama Therapy process, this would present itself as a group who was able to collaboratively create and perform scenes and improvise together. In a more traditional group therapy setting, this would present itself as a group, which supports each other and is able to express feelings to, and about, the group in a constructive way.

Program Restrictions

Group therapy is not for everyone**.** Even though this intervention is designed to facilitate group therapy with children that would usually struggle in a group setting, there are still going to be children for whom this model will not suffice. On a base level, children will need to be able to

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enter the treatment room and sit in a circle. If this is not accomplishable, then a different mode of treatment would be recommended.

Another group of children for whom this type of treatment will still prove to be difficult are sociopathic children, whom often engage in bullying other group members, attempting to manipulate the therapist, and creating negative emotional experiences for others (Grunblatt, 2016).

The Theraplay model suggests that the approach it uses is less than optimal therapeutic treatment for children who have been recently traumatized, are currently grieving, convalescing from surgery, or become severely dysregulated in the presence of new adults (Munns, 2009).

Appropriate Space to Play

As this intervention is an active play-based approach to treatment, having a space large enough to accommodate nine children and two adults is necessary. A theatre studio, a lunch room or gymnasium can work well. The space should be relatively free of distractions and should have a large open space free of chairs and tables for the group to gather and work. Smaller spaces could work for smaller groups, but it is recommended to have a space that allows for movement and individuals to be able to have their own space to work.

Therapist Training

Whereas most of the activities in Phase One and Two could be competently administered by most therapists with experience facilitating groups with youth, the move to Onoe's (2014) IDAM requires a level of competence in improvisation. Training in theatre, Developmental Transformations, or improvisation is recommended so that the therapist will be comfortable fa-cilitating scenes, and creating play, with clients who do not initially offer much content of their own to work with. It is the skills of the therapist as performer and creator that allows for initial success in scenes. As the group progresses, youth will be able to participate as equal players in scenes, but this will take a fair amount of modelling what successful improvisation looks like before youth will be able to do it on their own.

Chapter 6. RESEARCH LIMITATIONS

The validity and replicability of this research paper is not testable at this time due to the fact that it only used the first two of the five steps of a traditional Intervention Research model,

as outlined by Fraser and Galinsky (2010). A possible next step for this investigation would be to design a treatment trial based on this model and test its efficacy as a method to enhance group cohesion with hard to treat youth. This would involve a pre and post-test measure of attachment and a measure of group cohesion. Further areas of investigation could centre around differences in certain populations, namely, investigating if age, gender, DSM diagnosis, and other possible variables had an impact on a group's ability to function well together.

Another area of variability amongst group members, which may have an impact on an individual's growth through this process, is the level of dysregulation each individual brings to the group. There is a possibility that a group selected for a level of homogeny in this area may be more successful than if the group where comprised of various levels of need in regard to containment.

It was my intention to provide a well-rounded and grounded literature review of the topics covered, however, the diversity and breadth of the material did limit the depth in which certain areas could be investigated. There is a possibility that personal bias may have influenced some choices in the narrative produced by the literature review. In future investigations, the effects of this bias could be ameliorated by the soliciting professional feedback from experts in the areas of child trauma, attachment and group therapy.

In this paper, little attention was paid to cultural differences between the therapist and the group, or amongst the group members themselves. This issue could be another area of investigation as cultural differences around group participation may impact how a therapist chooses to use some or all of the ideas contained in this intervention.

Chapter 7. Conclusion

This research paper outlines an abridged version of an intervention research paper and provides a literature review on trauma, neglect, attachment, and group process with youth. This literature review was synthesized by the researcher based on the experience developed while working with hard-to-treat youth in various settings. By blending theory on attachment fostering therapy from Theraplay with the playful process-based treatment of Drama Therapy, a containing and nurturing intervention has been created. This intervention model proposes a Neurosequential Treatment Model (Perry, 2009) be used, first, to create a sense of safety and facilitate growth in

self-regulation, and then, foster experiences of social success and pleasure in order to broaden individuals' internal working models of self and other.

There are two difficult lines to walk when administering this intervention. Firstly, the line between structure and nurture must be navigated with care so that clients feel respected and appreciated, while at the same time they learn to follow rules and trust an adult's leadership. The second line to navigate is between boredom and challenge. If activities are 'too babyish' clients will feel bored and will choose not to engage, however, if the activities are too advanced and challenging, repeated experiences of failure will lead to feelings of disempowerment, shame and resistance. In this intervention, the therapist must be simultaneously loving and firm and the interventions must be accomplishable and challenging. By fostering repeated rhythmic, physical play, and slowly building towards social interactions, clients will be able to grow individually and as a group.

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